Revised October 2007

STATE OF IOWA
FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

Administered By:

State of Iowa
Iowa Department of Administrative Services

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THE BASICS OF FLEXIBLE SPENDING ACCOUNTS

What are Flexible Spending Accounts?

Flexible Spending Accounts (FSA's) are a way to pay out-of-pocket (unreimbursed) medical expenses (Health Care Flexible Spending Account (Health FSA)) and dependent care expenses (Dependent Care Flexible Spending Account (Dependent Care FSA)) on a BEFORE-TAX basis!

What Does "Before Tax" or "Pretax" Mean?

FSA deductions from your paycheck are exempt from federal and state income tax and social security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns.

Who is eligible to participate?

Permanent employees of the State, the Fair Board, the Community-Based Correctional Districts, the School for the Blind, and the School for the Deaf who are regularly scheduled to work at least 1040 hours a year are eligible to participate in the flexible spending plans.

Why Should I Participate?

The Health FSA can save you up to 25% - 40% in taxes on each dollar that you spend for your share of insurance deductibles, co-pays, and items not covered by insurance. Also, the Dependent Care FSA may save you more in taxes than the day-care tax credit (filed with your federal income tax return). See your personal tax advisor if you have questions.

Whose Expenses Qualify for these Plans?

Since these Plans are authorized by the Internal Revenue Code, medical expenses of a spouse or tax dependent (see www.asiflex.com for definition) qualify for the tax savings under the Health FSA even if they are not covered under one of the health/dental plans offered by the State. (There are age and custody restrictions for the Dependent Care FSA.)

TAX SAVINGS EXAMPLE

By electing to direct a portion of your salary through a FSA, you essentially bank your money in a TAX-FREE account. The money is used to pay for expenses that would otherwise be paid out of your take-home pay. **This example shows how an FSA could save this employee $602 in taxes.**

	Without ***FSA***	With ***FSA***	Savings with ***FSA***
Gross Income	$45,000	$45,000	
Expenses run through Health FSA = ($2,000 annual election)	0	2,000	
Taxable Income	$45,000	$43,000	
Federal Tax*	3,563	3,238	325
State Income Tax*	1,848	1,723	125
FICA	3,442	3,290	152
Income After Taxes	$36,147	$34,749	
Expenses not run through FSA	2,000	0	
Your Spendable Income	$34,147	$34,749	**$602**

This person could reduce their taxes by $602 by using the FSA!

*Based on married with two allowances.

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ENROLLMENT

The Plan Year is January 1 through December 31. Open enrollment normally begins mid-October, but you should check with your personnel assistant to confirm the actual dates. Participants must enroll each Plan Year to be eligible to participate.

You may enroll during open enrollment each year for the upcoming Plan Year by completing an enrollment form. Forms are available from your personnel assistant, ASI's web site at www.asiflex.com , and at http://das.hre.iowa.gov/fsa/home.html. You may also enroll during the Plan Year if you experience a qualifying change in family or employment status and enrollment is consistent with, and on account of, that status change.

New employees must enroll within 30 days of their hire date. Participants may begin to incur eligible expenses on the effective date of participation. Participation in the Plan will be effective the 1st day of the month following enrollment. Deductions will begin from the first available paycheck issued after receipt of the form by ASI and in conjunction with when your participation becomes effective.

HOW IT WORKS

1. Estimate your family's annual out-of-pocket medical and dependent care expenses.
You may include expenses for anyone who will be included on your federal tax return (spouse, children, etc.). Visit www.asiflex.com for information on qualified dependents. ***Include predictable expenses only***.

For the Dependent Care FSA, you may include only those child/dependent care expenses that you incur in order for you and your spouse to be gainfully employed. Only expenses incurred for care and well-being qualify for this tax break (education-related sports camps, summer school and private school expenses, food and transportation do not). **Child support payments are not allowable.** Day camp fees incurred in order for you to work are allowable but overnight camps are not. Please refer to IRS Publication 503 for further details on qualifying expenses. You may link to this publication from ASI's website www.asiflex.com.

2. Enroll
Divide your estimate by the number of paychecks you expect to receive during the Plan Year. Complete an enrollment form.

Deductions will be withheld from 24 (full calendar year) paychecks rather than the normal 26 received during the year. Twice a year employees receive three paychecks during a month. The third paycheck of a month does not withhold deductions for voluntary benefits, including the FSA.

3. Receive services.
An expense is **incurred** when the services are provided that create the expense, not when you are billed for or pay for the service. You must receive the medical or dependent care services before you file a claim for those services. The tax identification number or Social Security number of the child/dependent care provider must be listed on each of your claim forms and your federal income tax return. Please check with your dependent care provider (**before** enrolling in this category) to be sure that you are able to obtain their tax identification number or their Social Security number. Allowable expenses must be incurred during the portion of the Plan Year that you were a participant.

Service Period: If you are a Health Care participant as of December 31 of a Plan Year you may continue to incur expenses through March 15th to use any remaining funds in that Plan Year just ended. Claims for Health Care expenses incurred during this 2 ½ months are paid from the oldest year's funds first unless you request otherwise. If you are a Dependent Care participant as of December 31, 2007, all eligible expenses must be incurred by December 31, 2007. The service period will be extended to March 15 following the Plan Year effective with the 2008 Plan Year.

4. File claims.
After you have received the services and know the amount of your responsibility for the bill, you may submit a claim for those expenses to ASI. **Claims for expenses incurred for services provided during the Service Period must be filed by the following April 15th, or the next business day if April 15 falls on a weekend or holiday.** After that, your account will be closed and any balance remaining will be forfeited by you and will be retained by the State in accordance with federal regulations.

Copies of insurance explanations of benefits statements may be used instead of original physician bills if the date of service and charges are shown. Copies of receipts of payment that do not include all the above information are not acceptable. Copies of personal checks are not acceptable. Documentation or copies will not be returned. You will be provided with a supply of claim forms with your enrollment confirmation. Extra claim forms are available through your personnel assistant, from DAS's web site, ASI's web site, or by contacting ASI.

Orthodontic expenses may be assumed to be incurred at the time a monthly payment is due and paid. These monthly payments must be spread out evenly over the expected period of orthodontic treatment. Therefore, claims submitted for orthodontic payments that meet the above are allowable. You may also submit a claim for a reasonable down payment of the orthodontic treatment if the down payment is made at the time the appliances are placed. Claims for payments made prior to being due or that otherwise do not meet the above requirements will not be processed. Claims for the entire fee paid at the beginning of treatment will not be processed, nor will claims for an entire year's payments made at the beginning of the year be processed. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed.

5. Receive reimbursements.
ASI will review your claim and if approved, will reimburse you for the covered expenses. Payments are issued within one day of ASI's receipt of your claim. For dependent care, if your claim exceeds your available funds, the difference will be recorded and paid to you as funds become available from payroll. Payment under the Health FSA is not limited to the amount in your account at the time of your claim. Your bi-weekly contributions will continue for the remainder of the Plan Year.

Payments may be made by **direct deposit** into the bank account of your choice. By using direct deposit you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by **e-mail** over the Internet. If you prefer, a check can be mailed to you instead of payment by direct deposit

ANNUAL MAXIMUMS

You may elect to set aside up to $3,000 worth of qualifying expenses each year (but not more than your earned income) for the Health FSA.

For the Dependent Care FSA, you and your spouse (if any) together may include **up to a maximum of $5,000** per year, (**$2,500** in the case of a married individual filing a separate tax return for the Plan Year) or the lesser of your (after subtracting all FSA deductions) or your spouse's earned income for the Plan Year. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of $250 per month if you have one dependent and $500 per month if you have two or more dependents.

HOW TO MAKE CHANGES

In most circumstances, your annual election cannot be changed. You may make a change in your participation amount if you have a gain or loss of eligibility that is caused by a qualifying change in status. However, you might be able to make a change under the following circumstances:

1. You experience a change in status (defined below)
2. You are served with a judgment, decree or court order
3. You change your dependent care provider;
4. Your dependent care expenses change significantly; or
5. You go on a leave covered by the Family and Medical Leave Act (FMLA).

In order to request an election change, obtain a change of election form from your personnel assistant, DAS's web site, or ASI's web site and return the completed form within 30 days of the qualifying event to your personnel assistant.

Approved election changes are effective the first day of the month following the event and your submission of the request to change. Any increase in the election amount designated by a participant may include only those expenses, which the participant incurs on or after the effective date of the increase.

1. You experience a change is status

Changes in status are defined as any one of the following four events:

a. **Your legal marital status changes** through marriage, divorce, death, legal separation or annulment.

b. **Your number of dependents changes** by reason of birth, adoption (or placement for adoption), or death. For example, if your child no longer qualifies for day care because he or she turned 13, you have a loss of a dependent under the Dependent Care FSA, but not under the Health FSA.

c. **You have a change in employment status** that affects eligibility under this Plan and the change is consistent with the change in your employment status. If you terminate or take an unpaid leave of absence, you must be gone at least 31 days for the termination or leave of absence to qualify as a change in status. If your spouse or any of your dependents have an employment status change that affects eligibility under a Plan maintained by your spouse's or any dependent's employer, then you may increase or add coverage under this Plan if coverage is lost under the other employer's Plan, or decrease or drop coverage if coverage is gained under the other employer's Plan.

If participation terminates due to a separation of service and you return to state employment within 30 days in the same Plan Year, then your election will be reinstated as it was immediately prior to the separation of service. If you return to employment after 30 days in the same Plan Year, you may make a new election for the remainder of the Plan Year, provided you complete your new enrollment application within 30 days. If your contributions end for more than 30 days due to an unpaid status your participation/coverage will end. You will not be able to be reimbursed for Health FSA or Dependent Care FSA expenses incurred during the separation.

d. One of your dependents satisfies or ceases to satisfy the requirements for coverage under the Health FSA for unmarried dependents due to attainment of age, change in student status, or any similar circumstances.

The change in status must result in a gain or loss of eligibility for coverage under this Plan or a plan maintained by your spouse's employer or one of your dependent's employers and your election modification must correspond with that gain or loss of coverage.

For example, suppose you adopt a two-year-old child during the Plan Year. Since your number of dependents changed due to the adoption, you now have experienced a status change. Your child is eligible for coverage under the Health FSA and the Dependent Care FSA. You would be allowed to increase the amount you set aside in the Health FSA and the Dependent Care FSA, or enroll in either account if you were not already enrolled. However, you would not be able to decrease or drop either account because there was a gain of eligibility, not a loss of eligibility. A decrease does not correspond with the gain of eligibility.

2. You are served with a judgment, decree or court order

A judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for your child allows you to make an election change to your Health FSA. The change is allowed in order to provide coverage for the child if the order requires coverage under your Plan; or make an election change to cancel coverage for the child if the order requires your former spouse to provide coverage.

3. You change your dependent care provider

If you change dependent care provider, you may make an election change to reflect the cost of the new provider. Election decreases are allowed when your child is no longer in childcare or is only in after-school care due to entering Kindergarten or first grade (this is considered a provider change).

4. Your dependent care expenses change significantly due to a provider rate change

Significant changes include both increases and decreases in expenditures. However, you may only make a change, if the provider is not your relative.

5. You go on a leave covered by the Family and Medical Leave Act (FMLA)

If you take an FMLA leave, you may revoke an existing election under the Health FSA or Dependent Care FSA. Upon returning from FMLA leave, you may choose to be reinstated in either account if such coverage was terminated during the FMLA. Such reinstatement will be on the same terms as prior to taking FMLA leave. You have no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year.

A participant on unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) leave may

- **Cancel an existing Health FSA or Dependent Care FSA Election** for the remainder of the Plan Year, or
- **Continue Coverage** under a Health FSA while on FMLA leave.

You may not continue the Dependent Care FSA while on FMLA. However, you may reinstate coverage for the Dependent Care FSA when you return to work. You may continue coverage under the Health FSA while you are

on FMLA by paying the contributions due during your leave. These contributions may be paid in any one of the following ways:

1. Pre-pay
Under the pre-pay option, you may pay, prior to commencement of the FMLA leave period, the amounts due for the FMLA leave period. Contributions under the pre-pay option may be made on a pre-tax salary reduction basis from any taxable compensation. Contributions under the pre-pay option may also be made on an after-tax basis. Coverage under this plan will be terminated if you fail to make additional contribution payments while on FMLA leave as they may become required.

2. Pay-as-you go
Under the pay-as-you-go option, you may make contribution payments on the same schedule as payments would be made if you were not on leave or under any other payment schedule permitted by COBRA, or under any other system voluntarily agreed to between you and the State. Contributions under the pay-as-you-go option may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation that is due to you during the leave period. If you do not receive enough compensation to pay your full contribution, you must remit payment to your employer for the missing contribution on a post-tax basis.

3. Catch-up
You may make arrangements prior to the commencement of the leave to catch up contributions after you return from the leave. Contributions under the catch-up option may be made on a pre-tax salary reduction basis when you return from FMLA leave from any available taxable compensation. Contributions under the catch-up option may also be made on an after-tax basis.

If no election to continue is made prior to the beginning of an unpaid leave and contributions end for more than 30 days, coverage will automatically be discontinued. If contributions continue due to continuing paid status, coverage will continue.

If your coverage under the Health FSA terminated (due to nonpayment of contributions for more than 30 days) while on FMLA leave, you are not entitled to receive reimbursements for services incurred during the period when the coverage is terminated. However, you have the right to be reinstated when you return from leave. Election for reinstatement must be made within 30 days of returning to work. If you elect to be reinstated in the Health FSA upon return from leave for the remainder of the Plan Year, you may not retroactively elect Health FSA coverage for services incurred during the period when the coverage was terminated.

Your coverage for the remainder of the Plan Year is equal to your initial election for the 12-month period of coverage prorated for the period during your leave for which no premiums were paid, and reduced by prior reimbursements.

WHAT HAPPENS IF I TERMINATE EMPLOYMENT?

1. For Health FSA: If you terminate employment, you may continue coverage under the Health FSA in the following way.

You or your spouse or dependent may elect to continue the coverage under the Health FSA even though the participant's election to receive benefits expired or was terminated under the following circumstances:

1) Your death;
2) Termination (other than for gross misconduct) or a change in employment status;
3) Your divorce or legal separation;
4) A dependent child ceases to be a dependent under the terms of this Plan.

However, continuation is only available if on the date of the above event, your remaining potential annual benefits under the Health FSA are greater than your remaining contributions (including the additional 2% described below).

When ASI is notified that one of the events has occurred, the right to choose **continuation coverage** will be provided to each eligible person(s) if, on the date of the qualifying event, your remaining benefits for the current Plan Year are greater than your remaining program contribution payments. The right to elect to continue ends 60 days from the date the notice of the right to continue coverage is provided by ASI. It is the responsibility of the person seeking continuation to inform ASI of the occurrence of an event under 3) or 4). It is the employer's responsibility to inform ASI of an event under 1) or 2).

The remaining program contribution payments will be charged to you, your spouse, or your dependent, as the case may be, for any period of continuation coverage equal to, but not more than 102% of the cost of providing coverage for the period to similarly situated participants, spouses or dependents and the coverage period will be no longer than the end of the current calendar year. Any program contribution payment amount in excess of 100% of the cost of providing coverage for the period to similarly situated participants, spouses or dependents, shall not be credited to the participant's account but shall be treated as an administrative charge.

If continuation is elected, coverage will be extended to the end of the current Plan Year but may terminate sooner if the premiums described above are not paid within 30 days of their due dates.

Health Care FSA Coverage Options

Type of separation	Coverage options while on leave	Options on return to work
Furlough less than 31 days	No coverage	Mandatory reinstatement
Furlough 31 days or more	No coverage	May make a new election
Termination & re-hire within 30 days	No coverage (possible COBRA option)	Mandatory reinstatement
Termination & re-hire after 30 days	No coverage (possible COBRA option)	May make a new election
FMLA	May elect to continue coverage	May ask to be reinstated

If you go on furlough (or other non-FMLA unpaid leave) for a period of less than 31 days and the furlough does not affect your ability to make contributions to the Health FSA through payroll, then you will not lose coverage while you are on furlough. However, you will have no coverage during periods in which no contributions are made.

2. **For Dependent Care FSA:**
   If you **terminate employment**, you may continue to file claims for qualifying expenses incurred during the Plan Year until you have been reimbursed the balance in your account.

QUALIFYING HEALTH EXPENSES

Only the portion of the expenses you owe after insurance payments can be claimed. Qualifying expenses are those that are incurred by the taxpayer during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding all insurance premiums and long-term care expenses. Qualifying health care expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Refer to IRS Publication 502 for additional information (www.asiflex.com). **However, expenses qualify for the medical FSA based on when they are incurred, not when paid, and federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.** Over-the-counter drugs are reimbursable if purchased for a specific medical need, and not for general health. For more information on over-the-counter drugs visit www.asiflex.com.

Acupuncture services	Hearing aids including batteries
Alcoholism, drug or substance abuse	Insulin
Allergy Relief	LASIK eye surgery
Nursing services	Medical alert bracelet
Ambulance service	Midwife services
Artificial eye	Orthodontia (braces)
Artificial insemination	Over-the-counter reading glasses
Artificial limb/teeth	Oxygen
Bereavement & grief counseling	Drugs
Chiropractor's fees	Glasses
Christian Science Practitioners fees	Prosthesis
Contact lenses and solutions	Psychotherapy & psychoanalysis counseling
Co-pays	Routine physical exams
Deductibles	Smoking cessation
Dental expenses	Transfer of medical records charges
Dentures (bonding & sealants for dentures)	Transportation expenses related to illness
Doctor's fees	Vision care expenses

NON-QUALIFYING HEALTH EXPENSES

*Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins.
Sunglasses, non-prescription
Clip-on sunglasses
Toiletries
Expenses that are merely beneficial to your general health
Herbs, vitamins, and nutritional supplements (if purchased solely for general good health purposes)
Long-term care expenses

* *These do **not** generally qualify. For a medically necessary cosmetic procedure, enclose a note with the claim stating the existing medical condition and why the treatment is required.*

DEPENDENT CARE TAX CREDIT

The Dependent Care FSA is an alternative to taking a "Tax Credit" allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the "Tax Credit" or the "FSA". The IRS will not allow you to receive two tax breaks on the same expenses.

"Tax Credit" is allowed for child/dependent care expenses of up to $6,000 per year for two or more dependents ($3,000 per year for one dependent). You can file for the "tax credit" on your annual tax return, at the end of the year. The credit is an amount equal to your dependent care expenses multiplied by a percentage determined by your combined adjusted gross income. The percentage decreases from a high of 35% to a low of 20% as your income increases.

"Dependent Care FSA" allows a tax break on up to $5,000 per year, $2,500 if married filing separately, for any number of dependents (one, two, or more). You will experience "tax savings" throughout the year with every paycheck you receive. Employees who pay the lowest federal tax bracket of 15%, state taxes of approximately 6%, and Social Security taxes of 7.65% would save around 28% of expenses through the FSA. As their federal tax percentage rises, they would receive an even higher tax break by utilizing the FSA.

Generally those employees with a combined income over $31,000 or who spend more than $3,000 for care for one person would have a higher percentage tax break through the FSA. All other employees generally would receive a higher percentage tax break utilizing the Tax Credit. Please contact your tax advisor if you have any questions about what is best for you.

You are required to file Schedule 2 with your IRS Form 1040A or **Form 2441** with your IRS Form 1040 to support the amount contributed for the Plan Year. Please note that this is for informational purposes. You will not pay taxes on the redirected amount. Payments made to you under this category are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the Dependent Care Flexible Spending Account.

QUALIFYING DEPENDENT CARE EXPENSES

Expenses necessary for you to be gainfully employed. Refer to IRS Publication 503 for additional information. You can access this publication from ASI's website at www.asiflex.com.

- Expenses paid to a dependent care center
- Expenses paid to a "babysitter"
- Expenses paid for care of a dependent under age 13
- Expenses paid for care of a dependent who is physically or mentally incapable of caring for herself or himself who lives with you at least 8 hours each day (visit www.asiflex.com for specifics on qualified dependents)

NON-QUALIFYING DEPENDENT CARE EXPENSES

- Care while you are not working (including maternity, FMLA, and workers' compensation leave) or looking for work
- Care for a child for whom you have 50% or less physical custody
- Care for a child age 13 or older who is not disabled
- Overnight camps
- Instructional or sport-specific camps; e.g. ballet camp, soccer camp, summer school
- Expenses paid to your child under age 19 or to someone you or your spouse can receive a personal exemption for as a dependent.

APPEAL PROCESS

If ASI denies your reimbursement for a claim, you may file an appeal with the Iowa Department of Administrative Services. Appeals must be in writing and must be filed within 30 days of ASI's denial. Appeals must be sent to:

Flexible Spending Plan Administrator
Iowa Department of Administrative Services
Hoover State Office Building
1305 E Walnut, Level A
Des Moines IA 50319

Your appeal must be accompanied by ASI's written denial and any evidence you wish to submit to substantiate your claim.

Upon receipt of an appeal, the Plan Administrator shall provide a written determination within 30 days of receipt. This appeal process is not a contested case proceeding as defined by Iowa Code chapter 17A.

FREQUENTLY ASKED QUESTIONS

Q. WHY SHOULD I PARTICIPATE IN THE HEALTH FSA IF I ALREADY HAVE MEDICAL INSURANCE?

A. The Health FSA offers a tax break on medical expenses NOT reimbursed by insurance, such as non-covered expenses for office visits, co-pays, eye exams, medicine, and the portion of hospital care not covered by insurance.

Q. HOW MUCH DOES IT COST?

A. Currently, administrative costs of the Plan are paid by the State.

Q. WHEN CAN I MAKE CHANGES?

Generally, you will not be able to change your election during the Plan Year. Under certain circumstances however, you may be able to change your annual election. A change of election during the Plan Year due to a "change in status" must correspond with the gain or loss of eligibility caused by the change in status. For example, increasing your Health FSA would be consistent with the birth of a child. However, the birth of a child would not be consistent with a reduction in the Health FSA amount. Refer to HOW TO MAKE CHANGES on page 4.

Q. WHAT IF I AM ALREADY IN THE FSA. DO I HAVE TO RE-ENROLL?

A. Participation in both accounts terminates at the end of each Plan Year. You must re-enroll each year to continue your participation.

Q. WHAT IF I DO NOT USE ALL OF THE MONEY I SET ASIDE IN ONE OF THE FSA'S?

A. ASI can help you estimate your allowable expenses for the Plan Year. However, if you do have funds remaining in your account after the claims filing deadline, you will forfeit this unclaimed portion and the amount will be retained by the State of Iowa as required by federal regulations.

Q. WILL PARTICIPATION IMPACT MY SOCIAL SECURITY BENEFIT?

A. Probably, because you are not paying social security tax on that portion of your income that has been contributed, your social security benefits may be slightly reduced. However, if you invest your tax savings, in many cases you would have more money available at retirement than the benefit you would have received from the amount not paid into social security.

Q. HOW QUICKLY WILL MY CLAIMS BE PAID?

A. ASI will process your claim no later than the first banking day following the receipt of your claim. Dependent care claims will be paid on the day processed up to the balance in your dependent care account. Any excess dependent care claim balances not reimbursed will be paid as contributions are received from payroll. If there is a problem with your claim, ASI will notify you on the day the claim is processed either by U.S. Mail or by e-mail.

Q. IF MY SPOUSE AND I BOTH WORK FOR THE STATE OF IOWA, CAN WE BOTH ENROLL?

A. Yes, both of you will be allowed to enroll in the Plan. However, you can claim your spouse's medical expenses through your account. Therefore, unless your family's expenses will exceed $3,000, it might be best to have just one account. If both you and your spouse decide to enroll, each of you will have your own account and payroll deduction. Each of you will need to determine your own annual commitment up to the $2,500 maximum. You cannot submit a claim that your spouse has already filed, so careful planning and claim monitoring is important. Even though you may both enroll in the Dependent Care account, you are limited to an annual family maximum of $5,000.

Q. IS DIRECT DEPOSIT AVAILABLE?

A. Yes. You may have your claims payments sent directly to your checking or savings account. ASI will send a notice of each payment to you. ASI can send this notice via Internet *e-mail*. E-mail and direct deposit provide you with the fastest, safest payment method and the fastest notification method available. There is space on the enrollment form to include your bank account information and e-mail address.

Q. WHAT HAPPENS TO MY REMAINING HEALTH FSA UNCLAIMED BALANCE IF I TERMINATE MY EMPLOYMENT OR RETIRE?

A. If the remaining amount you are eligible to claim for the year is greater than the remaining amount of continuations (including the 2% COBRA fee), you will be offered COBRA continuation coverage through the end of the Plan Year. If your COBRA contributions would be greater than the amount you would be eligible to claim, then you will not be eligible for COBRA. Unless you select COBRA, your coverage will end when you leave State employment.

Q. HOW CAN I GET ANSWERS TO OTHER QUESTIONS?

A. Call ASI toll free at 1-800-659-3035. A representative is available from 7a.m. to 7p.m. Central Time. You may also e-mail ASI at asi@asiflex.com.

Q. HOW CAN I GET MY ACCOUNT BALANCE?

A. You can access your account on-line with a Personal Identification Number (PIN) from ASI by clicking on "Account Detail" at www.asiflex.com. Your PIN will be provided on your enrollment confirmation. You can also access your account information through InfoLine 125 by calling 1-800-366-4827 from a touch-tone phone. InfoLine 125 is an automated system available 24 hours per day. You can call ASI toll free at 1-800-659-3035. A representative is available from 7a.m. to 7p.m. Central Time or via e-mail at asi@asiflex.com.

Q. IF I REDIRECT PART OF MY PAY, WON'T I MAKE LESS MONEY?

A. Yes. Your paycheck will decrease, but your spendable income will increase by the amount of tax savings (See tax savings example on page two).

CLAIM FORM

Please read **requirements** on reverse side

State of Iowa

Last Name, First Name, MI (Please Print) _____ Social Security Number _____

Street Address _____ City, State, Zip _____

Dependent Care Assistance (day care, babysitting, etc.)

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	age	Dates Care Provided From	Dates Care Provided To*	Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period	ASI use only	
		Total Dependent Care Amount Requested →					

I provided the dependent care as stated above. _____ _____ _____

Care Provider's **original** signature | Date | SSAN/Tax ID#

Unreimbursed Medical Benefits

Date Medical Care **Provided***	Name of Medical Provider	General Medical Expense Description. Include medical condition for over-the-counter items.	Patient Name	Relation-ship	Amount that is your responsibility	ASI use only	
	Total Medical Amount Requested →						

↑ Please arrange documentation in order listed above.

*__Claims for future services will not be accepted__.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ Date _____

ASI
P. O. BOX 6044
COLUMBIA MO 65205-6044
FAX (866) 381-9682 toll free

← Mail or FAX to ASI **ALONG WITH SUPPORTING DOCUMENTATION**

E-mail: asi@asiflex.com
Internet http://www.asiflex.com

Claim Filing Requirements

1. ***Print your name, address and social security number.***

2. ***List expenses by date & arrange the supporting statements in the same order.*** Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
   - Day care claims - complete the Dependent Care Assistance section
   - Health care claims - complete the Unreimbursed Medical Benefits section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

3. ***Enclose required documentation**.*** A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing all of the following:
   - The name of the dependent care or medical service provider,
   - The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
   - A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),
   - The name of the person or persons receiving the medical or dependent care, and
   - The cost of the service, not just the amount paid.

   Dependent Care claims only. - You may either provide documentation from the day care provider or have the provider complete the Dependent Care Assistance Section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

   Requests filed without the above documentation cannot be processed and will be returned.

4. ***Sign*** the claim form.

5. ***Keep*** copies for your tax records.

6. ***Fax toll-free to 1-866-381-9682 or Mail*** to the address on the front of this form.

Over-the-counter medicines & drugs: Additional filing requirements for plans allowing these under the medical FSA:

- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- The participant must indicate the existing or imminent medical condition on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed. Purchases for general good health will not be accepted.
- To claim vitamins, herbs or nutritional supplements, you must have a written diagnosis of the medical condition and "prescription" of all specific items for that condition on file with the claims office. You must renew this physician notice every 12 months and file it with the claims office with the first claim submitted for those items each plan year.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.

Claims payment and account information available 24 hours a day 7 days a week: - Complete history including available funds *on the Web* at www.asiflex.com (Account Detail). You will need your P.I.N., which you can find on your enrollment confirmation.

Claim forms: You may copy this form, obtain forms on the Internet at http://www.asiflex.com, or request them from your personnel/payroll office, or call ASI at 1-800-659-3035 (442-3035 calling from Columbia, MO).

Sample Claim and Provider Documentation

This day care receipt contains the items the Internal Revenue Code requires:

1. It is signed by the provider of service - "*Ima Sitter*"
2. It contains a description of the services - "day care services"
3. It explicitly lists "1-2-04 to 1-08-04" as the range of the dates that the day care was provided.
4. It includes the amount charged for the day care "$300.00"; not necessarily the amount paid.
5. It identifies the person for whom the day care was provided - "*Mike Riddick*"

Day care documentation must contain all of these items in order to be processed.

I provided day care services for *Mike Riddick*

From *1/02/04* to *1/08/04*. The total sum for services provided was *$300.00*.

Signed *Ima Sitter*

Ima Sitter
123 Main Street
Columbia, MO 65203
SSN 123-45-6789

We must be able to identify the participant

MO CAFE

CLAIM FORM

Please read requirements on reverse side

Riddick, John M. — Last Name, First Name

111 — 22 — 4444 — Social Security Number

110 E. Ash St. — Street Address

Columbia MO 65203 — City,State,Zip

Dependent Care Assistance (day care, babysitting, etc.)

Name of Dependent	Age	Service Period From	Service Period To	Name, Address and Tax Payer Id number of Provider of service	Charge for Services	MSCEP use
Mike	10	*1/02*	*1/08*	*Ima Sitter, 123 Main St. Columbia MO 65203 123-45-6789*	*300.00*	
				Total Dependent Day Care Claim →	*300.00*	

I provided the dependent care as stated above _____ _____ _____

Care Provider's original signature — Date — SSAN/Tax ID#

Flexible Medical Benefits

Date Care Provided*	Name of Service Provider	Expense Description	Name and relationship of Person for whom expense incurred	Amount that is your responsibility	MSCEP use
01/05/04	*I William See, M.D.*	*Eye Exam*	*Mary - daughter*	*10.00*	
				Total Medical Amount Requested →	*10.00*	

Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent who is incapable of self care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

John M. Riddick — Employee Signature

01/08/04 — Date

The participant must sign the claim form.

Every request and all documentation must contain all the items shown in blue

Separate dependent care documentation is not required if the provider signs the form after the dependent care section is completed.

I. William See, MD
Ophthalmology
2020 Seymour
Crystalview, MO 65201

Service Date	Description	Charge for Services
01/05/04	*Eye Exam*	*$10.00*

Patient's Name *Mary Riddick*

This health care service statement contains the items the Internal Revenue Code requires:

1. It identifies the provider of service - "I. William See, MD"
2. It contains a description of the services - "*Eye Exam*"
3. It explicitly states the date of the eye exam - "1/05/04"
4. It includes the amount charged for the exam "$10.00"; not necessarily the amount paid at the time of service.
5. It identifies the person receiving the eye exam - "*Mary Riddick*"

Medical documentation must contain all of these items in order to be processed.

State of Iowa
Enrollment Agreement
20____ Plan Year

I wish to have my salary redirected beginning the 1st day of the month of _____, 20____ through **DECEMBER 31, 20___** in each of the categories below. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the State of Iowa Flexible Benefits Plan.

Social Security Number _____/_____/_____

Name _____
(Last, First MI)
Street _____

City _____
State, Zip

	Per Pay Period	# of Pay Periods	Total for the Plan Year	Not to Exceed
Health Flexible Spending Account	_____	_____	_____	$3,000
Dependent Care Flexible Spending Account	_____	_____	_____	$5,000*

* Cannot exceed $2,500 if married & filing separately

DIRECT DEPOSIT REIMBURSEMENT (Flexible Spending Accounts only)

I authorize ASI to credit my _____ (checking, savings) account number _____ at (name of bank) _____, with my Flexible Spending Account payments.
Please attach a copy of a check or a void check and write the bank's routing number _ _ _ _ _ _ _ _ _

E-MAIL

_____ I wish to receive my notification of direct deposit reimbursement via e-mail over the Internet at the address below.

E-mail address:_____

Employee's Signature:_____ Date _____

Return this form to your department's personnel assistant

ASI - 1-800-659-3035 email: asi@asiflex.com http://www.asiflex.com

PERSONNEL ASSISTANT USE ONLY:

Dept. 10 Digit #: _____ Hire date _____

Employees must be full-time or part-time and work 1040 hours annually on a regular basis to be eligible to participate in either flexible spending account. I certify this employee meets those eligibility requirements.

Personnel Assistant Signature: _____ Date _____